STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155793	A. BUILDING 01 B. WING	01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON TRACE OF FISHERS LLC	11851 CUMBERLAND RD FISHERS, IN 46037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/17/13 Facility Number: 012644 Provider Number: 155793 AIM Number: 201046710 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Hamilton Trace of Fishers, LLC was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all	K0000	February 8, 2013 Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Dear Ms. Rhoades: Please find enclosed the Plan of Correction to the annual Life Safety Code Survey conducted on January 17, 2013. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace's credible allegation of compliance. We allege compliance on February 16, 2013. We are requesting a desk review for this plan of correction. I	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	resident sleeping rooms. The facility has a capacity of 108 and had a census of 106 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services of supplies which was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/23/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:		If you have any further questions, please do not hesitate to contact me at (317) 813-4444. Sincerely, Melissa Hampton, HFA Administrator Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of Fishers of or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care other	

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			services provided in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Hamilton Trace of Fishers reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the deficiency. This plan of correction serves as the allegation of compliance by February 15, 2013. This statement of deficiencies and plan of correction will be reviewed at the April Quality Assurance/Assessment Committee meeting.	

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 Based on observation and interview, the facility failed to ensure 2 of 97 resident room corridor doors did not have an impediment to closing and latching. This deficient practice could affect 37 of 106 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 3:15 p.m. on 01/17/13, the corridor door to resident Room 417 and to resident Room 803 did not latch into the door frame. The latching mechanism on each resident room door failed to protrude into the latch plate on the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged each of the aforementioned doors did not latch into the door frame. 3.1-19(b)	K0018	**K18 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Room 417 and Room 803 door latches have been readjusted and when retested closed without failure. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents doors were retested and it was determined that no other doors failed to close/latch. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Resident room doors will be checked each month to determine that doors close without failure. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director or designee will complete visual and manual observation of resident room doors monthly for 3 months then quarterly therafter for a total of 12 months. Preventative maintenance will be completed as	02/16/2013

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			necessary. Results of the monthly audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 16, 2013.	

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K0027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8 Based on observation and interview, the facility failed to ensure 1 of 9 sets of smoke barrier doors would close to form a smoke resistant barrier. This deficient practice could affect twelve residents, staff and visitors in vicinity of the smoke barrier door set in the corridor by Room 801. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 3:15 p.m. on 01/17/13, the set of smoke barrier doors in the corridor by Room 801 swing in the opposite direction and were held open by a magnetic holding device. The east door in the set of smoke barrier doors failed to fully close when tested leaving a one half inch gap in between the set of doors. The top of the east door was stopped from	K0027	**K27 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The set of smoke barrier doors outside of Room 801 were readjusted. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents on 800 hall could be affected. **III The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** During monthly fire alarm checks the Maintenance Director or designee will monitor smoke barrier doors for proper closing. **IV The facility will monitor the corrective action by implementing the following measures.** Maintenance Director or designee will complete visual observation of smoke	02/16/2013

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	fully closing by rubbing against the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the smoke barrier door set in the corridor by Room 801 did not fully close because the top of the east door was stopped from closing by the door frame. 3.1-19(b)		barrier doors monthly for 3 months then quarterly thereafter for a total of 12 months. Preventative maintenance will be completed as necessary. Results of the monthly observation will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 16, 2013.	

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K0046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 Based on record review, observation and interview; the facility failed to document monthly testing for 2 of 2 battery operated emergency lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires requires a 30 second functional test to be conducted at 30 day intervals. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Individual results for all lights must be kept as part of the written record. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review of "Battery Operated Emergency Lights-Test Log for 2012" documentation with the Maintenance Director from 9:35 a.m. to 11:50 a.m. on 01/17/13, documentation of monthly testing at 30 day intervals for two battery operated emergency lighting systems was not available for review. The aforementioned testing log documentation had no results of monthly testing recorded after May 2012. Based	K0046	**K 46 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The battery operated lights have been tested to meet this requirement. There were no residents directly affected. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents have the potential to be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Director of Maintenance has been re-educated by the HFA on the Life Safety Requirement related to testing on battery operated lights and documentation. **IV The facility will monitor the corrective action by implementing the following measures.** The Director of Maintenance will perform audits of battery operated lights monthly for 3 months then quarterly thereafter for a total of 12 months. Results of the monthly testing will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews	02/16/2013

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	on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 3:15 p.m. on 01/17/13, two battery operated emergency lights were observed in the facility in the room where the emergency generator transfer switch is located and each light illuminated when their respective test button was pushed. Based on interview at the time of the record review and observation, the Maintenance Director acknowledged monthly testing documentation after May 2012 for each of two battery operated emergency lights was not available for review. 3.1-19(b)		will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 16, 2013.	

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K0050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 3 of 4 quarters. This deficient practice affects all occupants in the facility. Findings include: Based on review of Direct Supply: TELS "Fire Drills" documentation with the Maintenance Director during record review from 9:35 a.m. to 11:50 a.m. on 01/17/13, second shift fire drills conducted on 02/28/12, 08/30/12 and 11/30/12 were each conducted between 6:30 p.m. and 6:50 p.m. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned second shift fire drills were not conducted at unexpected times under varying conditions.	K0050	**K 50 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** There were no residents directly affected. Fire drills on second shift are now occurring at varying times. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents could potentially be affected, however none were identified. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Director has been re-educated as to the required components of this regulations assuring that the drills are conducted at varying times. Maintenance Director will inform HFA prior to conducting the fire drill the time of each drill to ensure varying times. **IV The facility will monitor the**	02/16/2013

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	3.1-19(b)		**corrective action by implementing the following measures.** Results of the fire drills will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 16, 2013.	

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K0052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to ensure 9 of 281 smoke detectors in the facility were not installed where air flow would adversely affect its operation. LSC Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires, in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:50 a.m. to 3:15 p.m. on 01/17/13, each of the following smoke detector locations was installed on the ceiling less than three feet from a supply or return vent: a. in the corridor by the Activities room. b. in the corridor by Room 307. c. in the Cherished Memories room. d. in the Main Hallway by the mechanical	K0052	**K 52 I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The nine smoke detectors were relocated to meet this requirement. There were no residents affected. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** Residents residing at the facility have the potential to be affected, however none were identified. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Director of Maintenance has been re-educated on the life safety requirement of smoke detectors being 3 feet away from an air vent. Maintenance Director or designee has observed smoke detectors within facility. Any smoke detectors found out of compliance were corrected. **IV The facility will monitor the corrective action by implementing the following measures.** Results of the	02/16/2013

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	room. e. in the corridor by Room 312. f. in the corridor by Room 416. g. in the corridor by Room 501. h. in the 400 Wing corridor by the oxygen transfilling room. i. in the corridor by Room 813. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned smoke detectors were each installed on the ceiling less than three feet from a supply or return vent. 3.19(b)		observations will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 16, 2013.	

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K0062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review, observation and interview; the facility failed to ensure sprinkler waterflow alarm devices were tested quarterly for two of four quarters. LSC 9.7.5 states all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, at 2-3.3 requires waterflow alarm devices including, but not limited to mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. NFPA 25, 9-4.4.2.1 requires the priming level to be tested quarterly. NFPA 25, 9-7.1 requires the fire department connections to be inspected quarterly. NFPA 25, 1-8.1 requires records shall be kept to indicate the procedure performed (inspection, test, or maintenance), the organization which performed the work, the results and the date. Finally, NFPA 25, 1-8 requires the records of inspection, test, and maintenance of the system and its components shall be made available to the	K0062	**K 62** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** There were no residents directly affected. Sprinkler systems were tested 4 th quarter of 2012 and have been scheduled for each quarter in 2013. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents could potentially be affected, however none were identified.	02/16/2013

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	authority having jurisdiction upon request. Typical records include, but are not limited to valve inspections, flow, drain, and pump tests; and trip tests of dry pipe, deluge and preaction valves. This deficient practice affects all residents, staff and visitors in the facility. Findings include: Based on review of J.A. Fire Protection Inc. "Report of Inspection" documentation with the Maintenance Director during record review from 9:35 a.m. to 11:50 a.m. on 01/17/13, a quarterly sprinkler system inspection was conducted on 04/27/12 in the second quarter of 2012 and on 11/26/12 in the fourth quarter of 2012 but no quarterly sprinkler inspection records for the first and third quarter of 2012 were available for review. Based on observation with the Maintenance Director during a tour of the facility from 11:50 a.m. to 3:15 p.m. on 01/17/13, the inspection tag affixed to the sprinkler system riser by J.A. Fire Protection Inc. had no inspection date recorded for the first and third quarter of 2012. Based on interview at the time of record review and observation, the Maintenance Director acknowledged documentation of quarterly sprinkler system inspection records was not available for review for the first and third quarter of 2012.		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Director has been re-educated as to the required components of this regulations assuring that the inspections occur quarterly. Maintenance Director has scheduled quarterly inspections and will provide HFA with paperwork following inspection. **IV The facility will monitor the corrective action by implementing the following measures.** Results of the inspections will be reviewed at the monthly Quality Assurance Committee	

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	3.1-19(b)		meeting and frequency and duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is February 16, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155793	A. BUILDING 01 B. WING	01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON TRACE OF FISHERS LLC	11851 CUMBERLAND RD FISHERS, IN 46037

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K0069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96			
	Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood's fire extinguishing equipment was inspected and approved every 6 months by properly trained and qualified persons. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, in 8-2 requires the inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire actuated water system shall be made at least every 6 months by properly trained and qualified persons. NFPA 96, 8-2.1 requires all actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire actuated dampers shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. This deficient practice affects occupants of the kitchen where five staff were observed on duty. Findings include: Based on review of Koorsen Fire & Security "Restaurant Systems Work Order" documentation with the	K0069	**K 69** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** There were no residents directly affected. Range hood fire extinguishing inspection was conducted on 9/12/12 and have been scheduled for semi-annual inspections in 2013. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** No residents were affected.	02/16/2013

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	Maintenance Director during record review from 9:35 a.m. to 11:50 a.m. on 01/17/13, the most recent range hood fire extinguishing equipment inspection report was performed on 09/10/12, however, a semiannual range hood fire extinguishing equipment inspection report prior to 09/10/12 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of a semiannual range hood fire extinguishing equipment inspection report prior to 09/10/12 was not available for review. 3.1-19(b)		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Director has been re-educated as to the required components of this regulations assuring that the inspections occur semi-annually. Maintenance Director has scheduled semi-annual inspections and will provide HFA with paperwork following inspection. **IV The facility will monitor the corrective action by implementing the following measures.** Results of the inspections will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.	

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			V. Plan of Correction completion date. Plan of Completion date is February 16, 2013.	